

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. ....

FILED JUL 27 1953

BIRTH NO. 36941015-53 REG. DIST. NO. 38 PRIMARY REG. DIST. NO. 4050 Registrar's No. 190

1. PLACE OF DEATH a. COUNTY <u>Boone Co. Missouri</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Boone</u>	
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Harrisburg</u>		c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <u>Harrisburg</u> <u>0100</u> <u>0</u>	
c. LENGTH OF STAY (In this place) <u>2 WKS</u>		d. STREET ADDRESS (If rural, give location) <u>---</u>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <u>-----</u>			

3. NAME OF DECEASED (Type or Print)	a. (First) <u>Cheryl</u>	b. (Middle) <u>Louise</u>	c. (Last) <u>Phillips</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>July 20, 1953</u>
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5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <u>Never married</u>	8. DATE OF BIRTH <u>July 2, 1953</u>	9. AGE (In years last birthday) <u>---</u>	IF UNDER 1 YEAR Months <u>---</u> Days <u>18</u>	IF UNDER 24 Hrs. Hours <u>---</u> Mins. <u>---</u>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Never worked</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	11. BIRTHPLACE (City and State or Foreign Country) <u>Boone Co. Missouri</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
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13a. FATHER'S NAME <u>Jason Phillips</u>	13b. MOTHER'S MAIDEN NAME <u>Katherine Arment</u>	14. NAME OF HUSBAND OR WIFE <u>-----</u>
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY NO. <u>None</u>	17. INFORMANT'S SIGNATURE OR NAME <u>Jason Phillips</u> ADDRESS <u>Harrisburg, Mo.</u>
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18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.	MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u>
	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <u>Acute respiratory infection</u>		
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last: <u>None</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION <u>none</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT SUICIDE HOMICIDE (Specify) <u>natural</u>	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) <u>none</u>	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) <u>Woodlandville Boone Mo</u>
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21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>none</u>	21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>none</u>
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22. I hereby certify that I attended the deceased from July 20, 1953, to July 20, 1953, that I last saw the deceased alive on July 20, 1953, and that death occurred at 8 A. m., from the causes and on the date stated above.

23a. SIGNATURE <u>Jim J. Shain Jr M.D.</u> (Degree or title)	23b. ADDRESS <u>La Hog, Fayette, Mo</u>	23c. DATE SIGNED <u>7-21-53</u>
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24a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	24b. DATE <u>7/20/53</u>	24c. NAME OF CEMETERY OR CREMATOR <u>Harrisburg Cemetery</u>	24d. LOCATION (City, town, or county) (State) <u>Harrisburg, Mo</u>
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DATE REC'D BY LOCAL REG. <u>July 22 1953</u>	REGISTRAR'S SIGNATURE <u>Mrs R.E. Palmer</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A. Case</u> ADDRESS <u>Fayette, Mo</u>
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WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by <sup>Not.</sup> \_\_\_\_\_

Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student .....  
Student Embalmer

Signed

*Joseph A. Carr*

Licensed Embalmer No.

*3340*

P. O. Address

*Jayette M*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.